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# Accepted Manuscript

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Karen Slade, Chiara Samele, Lucia Valmaggia, Andrew Forrester



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## Pathways through the criminal justice system for prisoners with acute and serious mental illness

### Author note:

Karen Slade<sup>1</sup>, Chiara Samele<sup>2</sup>, Lucia Valmaggia<sup>2</sup> & Andrew Forrester<sup>2,3</sup>

1. Division of Psychology, Nottingham Trent University, UK
2. Institute of Psychiatry, Psychology and Neuroscience, King's College  
London
3. South London and Maudsley NHS Foundation Trust

### Corresponding author:

Dr Karen Slade, Division of Psychology, School of Social Sciences,  
Nottingham Trent University, Nottingham, NG1 4BU  
Email: [Karen.slade@ntu.ac.uk](mailto:Karen.slade@ntu.ac.uk)

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## Introduction

Research has established that people in the criminal justice system exhibit higher levels of mental disorder than community samples, with increased levels of at-risk mental states amongst prisoners (Jarrett et al., 2015; Ogloff et al., 2011; Fazel et al., 2002; Shaw et al., 1999; Singleton et al., 1998). In England and Wales, there has been a dual service approach to the identification and management of these high morbidity levels, through national improvements in prison mental health services (Forrester et al., 2014) and liaison and diversion services (NHS England, 2016; Bradley, 2009). Where these liaison and diversion services are provided in courts and police stations, they generally offer fast access to mental health assessments for detainees (James, 2000). Following this initial assessment, they then provide their key functions of *liaison* (e.g. with community, hospital or prison-based services depending on the clinical need) and *diversion* (e.g. by referring onto community based services, or diverting people into a hospital bed). Therefore, these services offer a key care navigation role at the earliest stages of the criminal justice system in order to ensure that alternatives to prison custody for people who are vulnerable, or suffer from mental disorders, are introduced when possible. Yet although there is some evidence that these services can be beneficial (Scott et al., 2013), they have historically lacked consistency of funding and delivery (Dyer, 2013; Senior et al., 2011; Pakes et al., 2010) and their role in facilitating desistance remains unclear (Haines et al., 2014).

Evaluations of these services have generally reported local improvements where they have been introduced, along with a number of

limitations and difficulties within the criminal justice pathway. These barriers to service provision have included: variable service coverage; problems with information flow arising from incompatible systems and differing service demands; limited bed availability; differing organisational cultures; disputes regarding the outcome of assessments and the level of security required; disparity in the identification of medical needs and problems obtaining alternatives to custody (Roberts et al., 2012; Royal College of Psychiatrists, 2011; Senior et al., 2011; Chambers and Rix, 1999). The use of community alternatives for people with mental health problems has been particularly problematic, with Mental Health Treatment Requirements being systemically under-utilised (Scott et al., 2012). In addition, there have been concerns regarding the identification of mental disorder within the criminal justice system, with a bias towards the use of historical information that can be unreliable or incomplete (Birmingham et al., 1997; Coid et al., 2011) and evidence of serious screening difficulties in police and prison settings (Noga et al., 2015; Senior et al., 2013). Yet despite these limitations, there is good evidence that the use of health professionals can improve the identification of mental disorder during the early stages of the criminal justice system in police custody (McKinnon et al., 2010). However, it is likely that cases are often missed (Noga et al., 2015), raising questions about later arrival in prison with unidentified problems and risks, and the extent to which diversion at an earlier point in the criminal justice pathway would have been a preferred outcome for these individuals. Although imprisonment probably does not have a universally detrimental effect on mental health (Taylor et al., 2010), some groups are more vulnerable than others (Hassan et al., 2011). In particular,

there is a group of prisoners who enter prison with non-acute mental illness, then deteriorate significantly during the early stages of imprisonment (Hassan et al., 2011). The use of services to better identify and optimally manage this group has yet to be fully explored.

In order to understand these pathways better, this evaluation reviews individual journeys for those on the caseload of a prison mental health service, with a focus on cases displaying acute and serious mental illness in prison. Such mapping exercises have been recommended as one way of understanding clinical pathways through the criminal justice system (Dyer, 2013), but have hardly been taken forward within the existing literature. In implementing this recommendation, this evaluation aims to examine information across a range of criminal justice stages (police, court, prison) for people who have been directly imprisoned from court in order to:

- Identify evidence of symptoms of mental illness across stages of the criminal justice system pathway
- Review access to healthcare services and referrals for diversion at each stage
- Review the accessibility of mental health information across the criminal justice pathway

## **Method**

### **Design**

This service evaluation took place in a Local prison in London, UK. The prison holds a maximum of 1877 prisoners and serves a number of courts in the London area. It has a population that includes a high proportion of remand (44%) and foreign national (37.3%) foreign national prisoners (HMCIP, 2015).

A cohort method was used to review pathways into the prison's mental health in-reach team, and this team used an open referral system (Samele et al., 2016) through which all referrals were reviewed by nurse-triage within a maximum of 3-working days.

The project was approved as an evaluation by the relevant body within the local National Health Service Trust.

## **Procedure**

The evaluation used prison service and prison healthcare records that were already directly available to the mental health in-reach team (including: electronic healthcare records; prison system records such as the core record – also known as the F2050 - and the PNOMIS electronic record system). Demographic, court and offence information were also collected (including age, ethnic category, country of origin, current offence, dates of court and courts attended).

All records were reviewed for any record of mental health concerns or contact with a health professional, as outlined below.

**Police station.** All detained individuals are screened in police custody using a nationally agreed process during which initial mental health concerns can be identified (Noga et al., 2015). A hard copy of the screen and answers is then meant to follow arrestees who are subsequently received into prison custody, with this information then entering the prison file at reception (known as the F2050 file). In addition to any current concerns, historical information is available to the desk sergeants from the Police National Computer (PNC), and this can be used to inform their screening process.

Each detainee in police custody is asked questions regarding their health and risk of harm at the start of their detention. Responses are then recorded on the PNC and may prompt a referral to a clinician (Association of Chief Police Officers, 2006). These questions are as below:

- Do you have any illness or injury?
- Have you seen a doctor or been to hospital for this illness or injury?
- Are you supposed to be taking any tablets or medication?
- What are they and what are they for?
- Are you suffering from any mental health problems or depression?
- Have you ever tried to harm yourself?

If concerns are raised, there is a statutory form in which clinicians should record their contact, including information regarding any concerns and outcomes. These police forms are transferred within the F2050 prison record, but in this evaluation they were not transferred into all health records (within the sample, only 42 cases had an F2050 available for analysis because some prisoners had been transferred or released before researchers could access them, and only 31 of those contained a copy of the original police screening document).

**Court.** There is no statutory document for recording the content of contacts, or their outcomes, with health professionals or court liaison and diversion services. It is, however, standard practice for liaison and diversion services to contact (or liaise with) relevant services, often providing a short report or letter (particularly when onward referral is required). However, the Prisoner Escort Record (PER) is a mandatory document that is used to communicate information about risks, and it is used at all stages of the



criminal justice system when people are being transferred (Prison Service Order 1025, Ministry of Justice, 2009). It is always completed by escort staff, who record any concerns relating to health and safety and provide a log of any movements and contacts (including contacts with professionals such as solicitors and clinicians).

**Prison reception.** There are two stages to the health assessment provided on entry to prison. During the first night in custody, the mandatory screening tool (known as the F2169A or Grubin tool) is completed by a nurse (Prison Service Order 3050, Ministry of Justice, 2006). This 12-item health screening questionnaire involves a structured clinical interview with the prisoners, and the assessment includes five major sections, outlined below (Shaw et al., 2008):

**\*Insert Figure 1 here**

A cell-share risk assessment is also completed at reception, following assessment by both prison and health staff, to inform suitability for cell-sharing based upon an assessment of risk to others. The second part of health screening then occurs within the first few days of custody, and it is a follow-up screen which provides a more comprehensive health assessment.

**Sample**

All cases that were actively under the care of the prison's mental health in-reach team, and had been received directly into the prison from court (rather than being transferred in from another prison) were reviewed on two census days (10<sup>th</sup> August and 12<sup>th</sup> October 2015). After a number were excluded (because they were transferred or released before their health

records were reviewed, or were transferred from another prison or remitted to prison from hospital), 63 cases were examined from 123 on the caseload.

## Results

### Descriptive analysis

The sample's age ranged from 20 to 60 ( $M=34.5$ ;  $S.D.=10.11$ ), with 46 (73%) being on remand and 17 (27%) sentenced or subject to recall. It included 16 foreign national prisoners (25.4%). The ethnicity of the sample is outlined in Table 1:

**\*Insert Table 1 here**

### Acute cases

The sub-group 'acute cases' included 21 (33%) prisoners who presented with acute mental health concerns and required placement on the healthcare wing for their further management. The date on which they were determined 'acute' was either being placed on the waiting list, or placed on the healthcare wing (whichever was sooner). Within this sample, 21 (33%) displayed acute symptoms during their time in prison. The recorded working diagnoses for the full sample, and the sub-sample of acute cases, are outlined in Table 2:

**\*Insert Table 2 here**

### Pathways prior to imprisonment

From the whole sample, 29 cases (46%) were recorded as having been seen by a healthcare professional, by a liaison and diversion services, or a doctor (mostly forensic medical examiners in police custody or, in one case, a hospital doctor).

**Police station.** 42 of the 63 cases had a prison record accessible at the time of the evaluation and 31 had a police report available. Of the 31, the police report indicated current symptoms (including self-harm, bizarre or unpredictable behaviour) in 13 cases (43%), with 9 of these cases being seen in police custody by a clinician (29%). An additional five cases were assessed for physical health reasons (including Parkinson's disease, chest pain, drug use, and pain). One case was transferred to accident and emergency, returning to the criminal justice pathway a few days later. Of the 13 cases with symptoms identified in police custody, 6 (46%) subsequently became acute within the prison, while 3 of these cases were only assessed in police custody and not re-assessed at court.

**Court liaison and diversion.** Records showed that 19 cases had been seen across 6 courts, with 6 (31.5%) cases having previously been referred for mental health assessment while they were in police custody, and 13 additional cases being identified at the court stage. Of these 19 cases, 5 (26%) became acute within prison (of which 3 had also been seen in police custody). The level of detail available was sparse for many of these cases, and only one case was subsequently diverted (to hospital from prison), although two additional cases had been identified as potentially suitable for diversion. Of the cases that had been considered for diversion, but were instead remanded into prison, one had diversion delayed because of lack of bed availability, another was delayed because there were insufficient staff to enable transport to hospital, and the third case was initially remanded to prison before being transferred to hospital a few weeks later.

**Prison reception and pathways to acute symptomatology.** The prevalence of mental health risk identifiers as recorded from reception and secondary screening for the full sample and acute sub-sample are outlined in Table 4 below. The table indicates that there are similarities in prevalence between the groups, with slightly higher non-acute symptomatology identified at reception within the acute sub-group.

**\*Insert Table 3 here**

**Referrals to mental health in-reach.** This section reviews the timing and reasons for referral to the mental health in-reach team in order to evaluate whether professionals referred for historical reasons or because of current mental health concerns. The reasons for referral were classified into three categories:

1. Current mental health symptoms
2. Evidence of current or previous mental health medication requiring review or prescription
3. Previous contact with mental health services

The source and reason for referrals to the mental health in-reach team are outlined in Table 4 (in cases where there were two reasons for referral, both reasons are recorded separately in the table). Prison healthcare staff were most likely to refer people who were already receiving psychotropic medication, or who had previous contact with mental health services; while non-healthcare staff referred more evenly across current and previous concerns.

**\*Insert Table 4 here**

Of prisoners on the mental health in-reach caseload, 26 (41%) had been referred for concerns relating to current mental health symptoms, with 8 (12%) being referred directly from prison reception. The symptoms exhibited at reception which prompted referrals included: possible psychotic symptoms (e.g. auditory hallucinations, persecutory delusions and general paranoia), sometimes accompanied by agitation or aggression; low mood, depression or anxiety; limited verbal communication. Of those referred from reception for current symptoms, only two were considered acute at this early stage, with two cases later becoming acute (more than three months after they were received into prison).

**Interval from prison reception to acute status.** The 21 cases (33%) that displayed acute symptoms during their stay in prison had a Mean of 55 days (S.D. = 38.6) from reception to acute status. Table 5 outlines time to acute status for all cases, with only two cases identified within one week of reception and seven cases displaying acute symptoms within four weeks.

**\*Insert Table 5 here**

The pathway through the police court and reception process for the seven cases displaying acute symptoms within four weeks of reception are outlined in Figure 3. This review indicates that although current risk indicators were identified in six cases at the police station, only 3 cases were seen by a clinician prior to their imprisonment. Additional historical risk indicators identified at the prison reception stage suggested that those cases that were not seen pre-prison had a likely history of mental illness due to previous in-patient care.

**\*Insert Figure 2 here**

## Discussion

This evaluation sought to review mental health pathways through the various stages of the criminal justice system, with a focus on cases that later displayed acute mental illness in prison. It found a low prevalence of acute mental illness on reception to prison amongst this group, with most cases being referred at reception to the prison mental health in-reach team due to previous medication or mental health history, rather than current symptoms. Two critical areas were highlighted, and they require further review. Firstly, a discrepancy in service priorities may impact on later acute mental illness, whereby cases identified by police officers as displaying a high suicide risk are not subsequently reviewed by liaison and diversion services, but are at increased risk of displaying acute mental illness within four weeks of entry to prison. Secondly, inconsistencies in the availability of information, with mental health concerns not being transferred from prison service records to prison health files in approximately 13% of cases, and an increased presence of acute mental illness in these cases for which information was unavailable. Additionally, the lack of standardisation in information sharing from liaison and diversion services resulted in difficulties determining the services provided and their impact on outcomes.

In this evaluation, only very small numbers of cases exhibited acute mental illness on reception into prison (3%), a figure which is hard to compare with other literature in the field given sampling differences. Senior et al. (2013) reported a prevalence of 23% for severe mental illness in a two-phase prevalence study across six prisons in England, but it is now known how many of these were sufficiently acute to require direct admission to

healthcare, or subsequent transfer to hospital. Only two cases in this evaluation were planned for diversion at the court stage, with diversion then being delayed due to a lack of either available hospital beds or transport. Both cases were remanded into custody for over six weeks, reflecting findings in recent studies reporting excessive prison-hospital transfer times (Forrester et al., 2009; Hopkin et al., 2016): such remands may be unnecessary and could adversely influence the mental health of these prisoners (Goodmany & Dickinson, 2015). Although the sample's low acuity rate could be said to provide evidence for the effective operation of diversion services earlier in the criminal justice pathway, the fact that a third of the acute sub-sample (33%) went on to display acute symptoms within four weeks of their reception into prison does raise questions about the robustness of early identification systems, and access to comprehensive medical assessment by a forensic physician earlier in the pathway, and it suggests that improvements are still required (Senior et al., 2013; Martin et al., 2013; Birmingham, 2003; Chambers and Rix, 1999). A preference for prison reception screening to utilise historical information over current symptomatology is reflected in the reasons for referral to mental health services from reception. This finding is consistent with other studies in which healthcare staff were most likely to make referrals to mental health services because of previous contact with services and existing medication, with fewer cases referred because of their existing symptoms and none solely due to intellectual disability (Coid & Ullrich, 2011; Birmingham, 2003). Of the prisoners on the mental health in-reach caseload, nearly half (41%) had initially been referred with concerns relating to current mental health symptoms, but with only 30% of these being referred from

reception. As expected, prison staff were more likely to refer based on concerns regarding later behavioural concerns, with healthcare staff more likely to refer at reception based on historical indicators, in keeping with the screening requirements.

The evaluation identified a discrepancy in the focus of service delivery between pre and in-prison services, in relation to people at high risk of suicide, which the evidence suggests may be a missed opportunity to reduce the risk of acute symptoms in prison. Specifically, a number of cases displaying high-risk factors in police custody (current serious self-harm or suicidal ideation) were not subsequently reviewed by a clinician prior to their reception into prison, but the swiftly became acutely unwell in prison. Amongst all cases that displayed acute symptoms within the first month of custody, 85% had been identified with current mental health concerns in police custody. However, only those displaying current mental health symptoms without suicide risk indicators were seen by health professionals; with none of the solely suicidal being assessed. This may reflect differences between the perceived remit of liaison and diversion, and prison mental health in-reach services, with suicide risk being considered a higher priority for prison-based services (Ministry of Justice, 2011; Schilders & Ogloff, 2014). Interestingly, there was evidence that the suicide risk group also had a history of in-patient care, indicating previous acute mental illness. Although the reasons for this discrepancy are not documented, and therefore unknown, this may represent lack of service coverage (with court-based liaison and diversion services in particular often working only on a part-time basis), or it may reflect a simple absence of onward referrals between police custody and court-based teams.



In any case, this discrepancy now requires further examination in order to find a solution.

The evaluation identified that none of the sample were referred solely due to intellectual disability, although a screening for intellectual disability is completed on reception to prison. Since acute and serious mental illness, and referrals to secondary mental health services, were the focus of the evaluation and other referral pathways are available for people with intellectual disabilities (e.g. primary care mental health and a specialist intellectual disability clinic), firm conclusions about the pathways of people with intellectual disabilities cannot be drawn from this work. However, given the reported high prevalence of intellectual in prisons (Heerington, 2009) a more directed evaluation of intellectual disability pathways from prison reception may be warranted.

Regarding the sharing of mental health information, this evaluation demonstrated that the most consistent methods occurred within standardised systems in which the prescribed process required a specific response. In particular, police custody forms with related clinician reported (e.g. formalised HealthCare Professional, or Forensic Medical Examiner reports) were generally complete and present within the prison records. However, even where there was evidence of contact with court-based liaison and diversion services (for which there is no standardised process, or form), the content was highly variable, with limited detail in many cases. In addition, only 36% of the sample provided GP details at reception; leading to delays in gaining relevant health information and a reliance on self-report and mental health information from police and court services. This figure is lower than those

reported for police custody (85%; Forrester et al., 2016) and may reflect differences in population, process or recording practice. In relation to the use of mental health information at reception, 13% of cases had relevant mental health information solely within their prison files, which had not been transferred into health files. This was especially so for the police risk assessment forms and their related clinical records. Since none of these cases were referred at reception, but a high percentage of them (50%) later displayed acute symptoms, a review of standard practices is needed to ensure that all health information held within prison records is also routinely made available within health records.

Finally, the evaluation considered prisoners with severe mental illness who had previously been discharged from prison or hospital, and whether this affected the likelihood of becoming acutely unwell in prison. Although the evaluation did not find a relationship between the length of time since discharge and the likelihood of displaying acute symptoms, the length of time between discharge and re-entry for the full sample (382 days) is remarkably similar to the 385 days reported elsewhere (Cloyes et al., 2010). This group reported that severely mentally ill offenders returned to prison twice as quickly as their non-mentally ill counterparts. The effectiveness of resettlement and community services for those discharged from prison and hospital in preventing re-offending and prison re-entry remains a concern, despite some promising recent developments (Draine & Herman, 2007; Jarrett et al., 2012).

This study is the first to consider pathways through the criminal justice system for people with severe and acute mental illness under the care of a prison mental health in-reach team, but its results are limited by the use of

only one site: it is recommended that similar studies are undertaken in similar pathways elsewhere. By including all cases that would experience a similar service within a locality, it is possible to determine the likely risks and the prevalence of acute mental illness on entry to prison amongst a high-risk mental health group. However, in order to allow the evaluation to compare similar services, a number of cases were excluded with effects on the sample size and, as such, the analysis is limited in the strength of some of its conclusions. The study is limited to cases on the mental health in-reach caseload, and therefore conclusions cannot be drawn in relation to the wider prison population, or to cases diverted before custody. The information used included data that were already available to health and/or prison staff and may not fully reflect liaison and diversion services (from which information was often limited), or be fully accurate (particularly given the need for self-report across the criminal justice pathway). In addition, symptoms and diagnoses in this evaluation were drawn from those recorded within the prison health record system based upon the professional opinion of the prison psychiatric and mental health services and referring and previous inpatient services. Standardised diagnostic assessments were not completed given the pathways focus, and the evaluative nature of this work, and diagnostic variability may therefore be present. Due to a lack of standardisation in the information available from the court stage, there were difficulties in determining the exact nature of service provision and its impact on outcomes. Nonetheless, this does reflect the real information that is available to health staff when they make decisions about onward referrals.

## **Conclusions**

There is a recognition that severely mentally ill offenders are complex and require the co-ordination of many services across stages of the criminal justice system, and following discharge from prison or hospital. This evaluation identifies the presence of effective practice, with some areas for development:

1. Most cases with identified mental health concerns were reviewed in police custody by health professionals, and these records were largely available throughout the criminal justice system. However, there were serious problems with subsequent court assessments, with limited information and few cases considered for diversion, and cases demonstrating current suicidality often being overlooked. Wider service coverage could ensure that cases are not missed, with assessments being undertaken at the earliest stages of the criminal justice system.
2. Where a risk of suicide is identified, this should lead to referral for further mental health assessment, and information transfer across the pathway should be prioritised.
3. The number of acutely mentally ill people arriving at prison reception is small, suggesting that despite any inefficiencies, the earlier parts of the pathway are identifying and managing those with acute mental illness. However, a sizeable number become acutely unwell within a relatively short period (28 days), and many of these had pre-existing vulnerabilities suggesting that their subsequent deterioration is, to an extent, predictable.
4. Serious problems with information flow across the various systems interfere with identification and service access, and need to be urgently

remedied. We recommend a unitary solution (i.e. one electronic healthcare record across the criminal justice pathway) for this purpose.

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**Tables****Table 1: Ethnicity for sample**

Ethnicity	Number
White British or Irish	28
White other	6
Black/Black British: Other	2
Black/Black British: African	5
Black/Black British: Caribbean	2
Asian: Other	9
Asian: Pakistani	1
Mixed (White/Black Caribbean, Black African or Asian)	3
Other	6

**Table 2: Working diagnosis for full sample and sub-sample of acute cases**

Working diagnosis or symptom	% of sample (N = 63)	% of acute cases (N = 21)
Schizophrenia/Psychosis	52.4	58.3
Depression	25.4	20.8
Substance use	22.2	16.7
Bipolar	14.3	12.5
Paranoia	6.3	12.5
Personality disorder	11.1	12.5
PTSD	3.2	8.3
Self-harming behaviour or suicidality, without other mental health diagnosis	6.3	4.2
Obsessive compulsive disorder	1.6	4.2
Autism spectrum disorder	1.6	0
Attention deficit hyperactivity disorder	6.3	0

**Table 3: Reception information: number and percentages for full and acute sub-samples**

	Number Total (%) (N = 63)	Acute (% of sub-sample) (N = 21)
Seen prior to prison by clinician (at police station or court)	29 (46%)	11 (52%)
Information provided at reception/secondary screen of previous and/or current mental health issue	45 (71%)	18 (75%)
Previous psychiatric medication reported	33 + 6 <sup>1</sup> (62%)	10 + 4 <sup>1</sup> (66%)
Current psychiatric medication (not on entry to prison)	29 + 3 <sup>1</sup> (51%)	9 + 2 <sup>1</sup> (52%)
Known to community mental health team	32 + 9 (65%)	13 (62%)
Previous notes within prison's electronic records	37 (59%)	11 (52%)
Previous admission to psychiatric hospital	33 + 6 <sup>1</sup> (62%)	11 + 3 <sup>1</sup> (66%)
GP identified at reception/secondary screen	23 (36%)	7 (33%)
Mental health symptoms identified at reception (all non-acute e.g.	11 (17%)	6 (29%)

anxiety, low mood, self-harm)		
Referrals to mental health team at reception or secondary screen	32 (15%)	9 (42%)

1 The added number is where information was identified post  
reception/secondary screen

**Table 4: Source and reason for referral to prison mental health service**

Source	Current symptoms	Medication	Previous mental health history
Reception screening	6	19	11
Secondary screening	2	0	2
Other healthcare staff	5	2	2
External source	3	2	1
Prison staff	4	3	2
Court	4	3	2
Self-referral	2	0	0
Total	26	29	20



**Table 5: Interval to acute status after being received into prison**

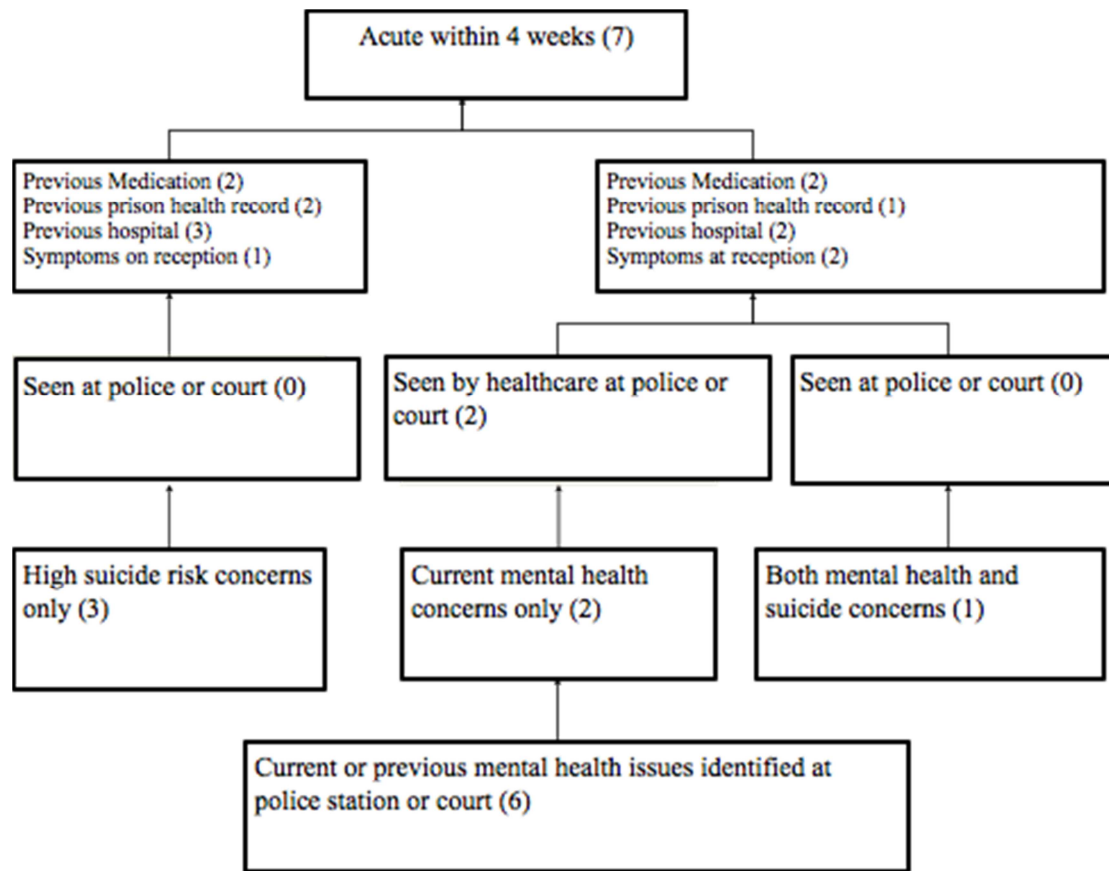
Interval	Frequency	Percent (%)
Within 1 week	2	3.2
1-2 weeks	1	1.6
2-3 weeks	2	3.2
3-4 weeks	2	3.2
1-2 months	5	7.9
2-3 months	5	7.9
> 3 months	4	6.3

## Figures

**Figure 1: Screening assessment on prison reception**

1. Personal information	Name, date of birth, address, GP details, prisoner status
2. Physical health	Current mental problems and outstanding appointments, prescribed medication, injuries sustained, chronic disease, allergies, observations
3. Substance misuse	Alcohol use, drug use, risk of withdrawal, urine screening results
4. Mental health	Psychiatric contact history, medication, suicide/self-harm risk, observations
5. Planned actions	Referrals, interventions, fitness for work, location needs

**Figure 2: Pathways through police, court and prison reception for acute cases within 4 weeks of entry to prison**



**Highlights**

- Pathways taken by mentally ill prisoners were evaluated (n=63)
- A small number were acutely ill at prison reception (3%)
- A third (33%) later developed acute symptoms
- People with suicidal ideas may be overlooked
- One electronic record across the criminal justice pathway is proposed

Word count = 44